PRINTED: 09/29/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		165533	B. WING _			R-C <b>09/17/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIA	DATE.
{F 000}	INITIAL COMMENTS	3	{F 0	00}		
{F 580} SS=D	9/17/20 resulted in th See Code of Federal 482, Subpart B-C.	rvey completed 9/16/20 - ne following deficiencies. Regulations (42CFR) Part njury/Decline/Room, etc.) 1)(i)-(iv)(15)	{F 5	80}		
	§483.10(g)(14) Notifi (i) A facility must immonsult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and hybrician intervention (B) A significant charmental, or psychosodeterioration in health status in either life-th clinical complications (C) A need to alter to a need to discontinuous treatment due to advommence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this sectionall pertinent informatics available and proviphysician. (iii) The facility must resident and the resident there is- (A) A change in room	cation of Changes. nediately inform the resident; lent's physician; and notify, ther authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to em of treatment); or esfer or discharge the				(Ve) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TLE (X6) DATI

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTR	UCTION	(X3) DATE COMP	SURVEY
		165533	B. WING				-C <b>17/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		1 03/	17/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	State law or regulatio (e)(10) of this section (iv) The facility must rupdate the address (rephone number of the representative(s).  §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configuratiocations that comprise part, and must specifications that comprise part, and must specificate with the second control of the secon	ent rights under Federal or as as specified in paragraph.  record and periodically mailing and email) and resident  osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations  is not met as evidenced sew and staff interview, the the physician of changes for wed (Resident #5). The issus of 46.  et (MDS) completed with an one Date (ARD) of 7/1/20 iew for Mental Status dicating severe cognitive dent required extensive ff with toileting and personal trused an indwelling catheter	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	, , ,	(X3) DATE SURVEY COMPLETED	
		165533	B. WING			R-C 9/17/2020
	ROVIDER OR SUPPLIER  BOLDT NORTH, LLC			STREET ADDRESS, CITY, STATE, ZIP 1111 11TH AVE NORTH HUMBOLDT, IA 50548	•	19/11/12020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 580}	the resident's cathet resident complained insertion of the cathet redness and a red so Advanced Registere responded they would be a responded to a responded t	form dated 9/3/20, showed er was changed. The of pain with the removal and eter. The penis showed treak to the base. The d Nurse Practitioner (ARNP) Id see the resident that day.  Progress Note dated 9/3/20 ported the resident during their catheter change ed streak going up the penising the penis, the resident d complained of discomfort bing moved. The the resident had cellulitis of the inic indwelling catheter. The was to start Cephalexin 500 etimes a day for ten days, ew or worsening symptoms. Was to follow-up in one week on's signs and symptoms esolved, or sooner as needed as encouraged to call with any mptoms, or concerns. The ed erythema and tenderness. The resident's white blood	{F 5	80}		
	The catheter was ch not enough output to	efore starting the antibiotic. anged in the afternoon, with measure at 6:00 PM. At approximately 250 milliliters				

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		165533	B. WING _			R-C 09/17/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		3311112020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 580}	yellow with thin strips blood throughout. The with a temperature of (F).  On 9/6/20 at 10:58 As a call placed to the reconsent for COVID-1 consent to test the reneeded during an outon on 9/9/20 at 5:22 AN the resident found si with back resting on complaints during the Three staff assisted issues noted. The re (ROM) as per usual, and bear weight with bruising noted to the lengthening or shorte extremities with no redenied any pain and resident's handgrips dizziness. The resident of the resident of the length of the	ag. The urine was a medium of of medium to dark red the resident remained afebrile of 97.5 degrees Fahrenheit.  AM, the Nursing Note showed the esident's son to receive the sesident on Tuesday and as a subreak.  AM, the Nursing Note showed the esident on Tuesday and as a subreak.  AM, the Nursing Note showed the triang on the floor in the room the bed. The resident had no be physical assessment. The resident with note is subreak to stand the resident with note is subreak to stand the resident with note is subreak to the edness of the edness of the edness noted. The resident was confused per usual. The were equal and denied the edness noted to the edness note	{F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165533	B. WING				-C 17/2020
	ROVIDER OR SUPPLIER			1111 11	T ADDRESS, CITY, STATE, ZIP CODE  TH AVE NORTH  OLDT, IA 50548	1 09/	17/2020
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	around 5:40 AM; the with no cough noted of a temperature of 9 respirations 24, a bloan oxygen saturation.  The Long-Term Care Visit dated 9/10/20, swas a follow-up of the of the present illness was started on cephacellulitis of the penis streak going up the sof the visit on 9/3/20, clear with a normal V the last visit, the staff The staff reported the injuries but had beconstaff noticed a decrearesident refused to eweek. The resident houring the overnight temperatures as high a negative test for the (COVID-19) on 9/7/2 if the resident's signs cellulitis to the penis	M, the Nursing Note g during the medication pass resident had audible wheeze. The resident had vital signs 17 F, a pulse of 77, and pressure of 128/78, and of 94% on room air.  Progress Note - Routine showed the chief complaint e penis cellulitis. The history (HPI) showed the resident alexin the week before for when the staff noted a redishaft of the penis. At the time the resident's urine was VBC count on 9/2/20. Since f noted increased weakness. The ase in oral intake as the at a few meals during the and decreased urine output hours with elevated as 99.7 F. The resident had an as 99.7 F. The resident had an as 99.7 F. The resident had an as ymptoms of the improved. The staff had no as assessment showed the stative Care	{F 5	80}			

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		165533	B. WING			R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1111 11TH AVE NORTH HUMBOLDT, IA 50548	CODE	09/17/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 580}	cellulitis of the penis in symptoms. Due to decreased oral intak few days ago, plan to obtain a urine culture the ARNP planned to to weakness, milky usoner PRN. The stawith any worsening sconcerns. The Physi without erythema bu leaking around the complete of the ARNP. Upon evaresident had copious discharge leaking around the ARNP. Upon evaresident had copious discharge leaking arounder was received for blood count with diffecomprehensive metadone on 9/10/20. The catheter with 16 Free obtained a urine same culture. The nurse good and very foul-smelling the lab to come and the New Orders for orders for a urinalysis and a CMP to be done. The CBCD results continued the WBC count of 9.4.0 - 10.5. The result were reviewed. Staff	entinue on cephalexin for the with significant improvement the increased weakness, e, and a fall that occurred a codraw lab and have staff e. The follow-up plan showed of follow-up in one week due trine, decreased appetite, or aff was encouraged to call signs, symptoms, or cal Exam showed the penis to with milky colored urine atheter.  AM, the Nursing Note was seen during rounds by aluation by the ARNP, the samounts of white/yellowish bound the catheter. A new for a urine culture, a complete erential (CBCD), and a abolic panel (CMP) to be the nurse changed the current and the correct and the penis to the ordered urine to the ordered urine to the ordered urine to the ordered urine that was cloudy g. The facility was waiting for obtain a blood sample.  In dated 9/10/20 showed new is (UA) with a culture, CBCD,	{F 5	580}		

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	ROVIDER OR SUPPLIER	100000		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548		/17/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 580}	than it was eight days On 9/10/20 at 3:35 PI indicated a return fax results for the CBCD new orders at the time On 9/10/20 at 4:01 PI explained a return fax showed results from t ARNP stated the resu staff was to encourag they were waiting for The ARNP's nurse sta was aware of the resu within normal limits, b ago. The ARNP's nurs informed they were w On 9/12/20 at 12:23 A indicated the resident puss-like substance w collection bag. The re nurse was waiting for (C&S) of the UA. The of 97.5 F. On 9/13/20 at 1:02 AI the resident continue of 98.2 F. The urine of urine bag. On 9/13/20 at 1:57 PI the UA Culture return 1. greater than (>) 10 (CFU) / ML of Proteus	In normal limits but higher is ago.  M, the Nursing Note received from the lab with and the CMP showing note.  M, the Nursing Note received from the ARNP the CBCD and CMP. The allts were reviewed, and the effuids. The ARNP stated the results of the culture, and that Resident #5's son alts and that WBC was still but higher than eight days se stated the son was raiting for the culture results.  AM, the Nursing Note continued cephalexin. A was observed in the urine resident denied pain. The the culture and sensitivity resident had a temperature when the the culture and sensitivity resident had a temperature when the the culture and sensitivity resident had a temperature of the Nursing Note showed and ATB's with a temperature of the Nursing Note showed and the Nursing Nur	{F 58	0}		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 11TH AVE NORTH HUMBOLDT, IA 50548	•	03/11/2020
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{F 580}	explained the resider The resident's tempe resident continued to around the catheter.  On 9/14/20 at 2:47 P explained the facility the ARNP with result 9/10/2020. The ARNI reviewed and to cont  On 9/14/20 at 4:25 P indicated the residen	PM, the Nursing Note at finished the cephalexin. rature was 98 F, and the have pain and discharge  M, the Nursing Note received a return fax from so from the urine culture on postated results were inue on the cephalexin.	{F 58	0}		
	were as follows: 1. C extended-release (Ef Probiotic everyday 3. to the reddened area PRN.  The New Orders form ARNP gave orders for every twenty-four hordaily, and apply the preddened areas of th  The Laboratory Resulthe UA Culture return 1. greater than (>) 10 (CFU) / ML of Proteu of Enterococcus Fae Pseudomonas Aerug the urine culture show reviewed, and the rescephalexin.	iprofloxacin 500 mg R) every day for five days 2. Apply a protective ointment is of groin twice daily and in dated 9/14/20 showed the process of five days, a probiotic protective ointment to the ending groin twice daily and PRN.  Alts noted on 9/14/20 showed led with the following noted: 100,000 colony-forming unit is Mirabilis 2. 30000 CFU/ML calis 3. 100000 CFU/ML of inosa. The result notes for wed the results were				

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{F 580}	urinary retention. The a history of urethral of 9/16/20, an ATB was problem included the 1. History of a UTI, E not contraindicated. PRN. Probiotic as or 2. Monitor urethral er of bleeding, swelling 3. Monitor, documen symptoms of a UTI scloudy, dark, concent and changes in ment Report to the nurse on the nurse of noted dated 2/5/19.  With a revision date included a problem to a self-care deficit relistatus. The resident cardiomegaly, atrial of the Care Plan problem to the nurse urine, complaints of urination, frequency, provider dated 2/22/2. The resident was the need to use the tresident to the toilet. The staff was to repositive of the staf	elimination using an elated diagnosis of BPH and eresident was admitted with erosion from the catheter. On ordered. The Care Plan efollowing interventions. Incourage fluids as long as May offer cranberry juice dered dated 9/15/20. To sion weekly for symptoms and pain dated 6/2/19. It, and report PRN signs or such as foul-smelling urine, trated urine, low back pain, tall status or alertness. For provider if symptoms were provider if symptoms were and a diagnosis of fibrillation, and sleep apneariem included the following the any unusually foul-smelling pain or discomfort with and/or urgency to nurse or 19. The able to recognize and voice oilet. Staff was to assist the per their request and PRN. The and the catheter leaking or	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165533	B. WING	_		l	-C
NAME OF PI	ROVIDER OR SUPPLIER	165533	B. WING	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	17/2020
QHC HUM	BOLDT NORTH, LLC				11 11TH AVE NORTH UMBOLDT, IA 50548		
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{F 684} SS=D	always getting all the The ARNP said when the resident's condition going on. Until the AR 9/10/20, they were unthe resident's urine. The resident up to assess around the catheter. Communication regard conditions had not im ARNP said the staff's resident's urine if the conditions.  On 9/17/20 at 2:07 PI Preventionist said the their communication of Quality of Care CFR(s): 483.25  § 483.25 Quality of care CFR(s): 483.25  § 483.25 Quality of care is a further applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profess practice, the comprehence of the comprehence	the residents due to not information from the facility. They asked the staff about on, no one knew what was RNP saw the resident on naware of any concerns with then when they stood the the penis, urine was leaking The ARNP stated the ding the resident's proved since 7/20. The hould be assessing the resident had those  M, the Infection e facility needed to work on with the Doctor's office.  Are ndamental principle that not and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered	{F 6				

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  BOLDT NORTH, LLC	100000		STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548	l	09/17/2020
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{F 684}	Continued From pag	e 10	{F 68	34}		
	Findings include:					
	Assessment Referent showed a Brief Intervor (BIMS) score of 4, in impairment. The resident assistance of one start hygiene. The resident for urinary elimination diagnoses of urine resident (BPH) with symptoms, and acute A Physician Fax Form resident's catheter work complained of pain work of the catheter. The pred streak to the bas Nurse Practitioner (Asee the resident that	tention, benign prostatic ithout lower urinary tract e cystitis without hematuria.  In dated 9/3/20, showed the as changed. The resident with the removal and insertion penis showed redness and a e. The Advanced Registered RNP) responded they would day.				
	showed the nurse recomplained of pain dath that morning with a reshaft. Upon assessing became agitated and when the catheter tules.	ported the resident uring their catheter change ed streak going up the penis g the penis, the resident complained of discomfort				
	the penis and a chroloplan for new orders willigrams (mg) three and staff to report ne The follow-up plan with to ensure the infection were improving or research.	rice resident had centulitis of nic indwelling catheter. The was to start Cephalexin 500 e times a day for ten days, w or worsening symptoms. as to follow-up in one week n's signs and symptoms solved, or sooner as needed encouraged to call with any				

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{F 684}	physical exam showed present in the penish cell (WBC) count was cell (WBC) at 1:16 AM the resident started of Nurses Aide (CNA) at (CMA) stated the resident contenual policy of urine in the base of the catheter was channot enough output to 10:00 PM, there were (ml) of urine in the base yellow with thin strips blood throughout. The with a temperature of (F).  On 9/7/20 at 6:39 PM the resident continue irritation to the penish complaints.  On 9/9/20 at 5:22 AM the resident found sit with back resting on complaints during the Three staff assisted in incomplaints during the Three staff assisted in incomplaints during the Three staff assisted in the lengthening or shorted extremities with no redenied any pain and resident's handgrips dizziness. The residential country in the penish complaints with the lengthening or shorted extremities with no redenied any pain and resident's handgrips dizziness. The residential country is the penish country in the penish country	nptoms, or concerns. The ed erythema and tenderness The resident's white blood is 4.69 on 9/2/20.  If, the Nursing Note showed dephalexin. The Certified and Certified Medication Aide ident had diarrhea that effore starting the antibiotic. anged in the afternoon, with measure at 6:00 PM. At el approximately 250 milliliters ag. The urine was a medium of medium to dark red are resident remained afebrile of 97.5 degrees Fahrenheit  If, the Order Note explained do n an oral antibiotic for the with no changes or  If, the Nursing Note showed thing on the floor in the room the bed. The resident had no el physical assessment. In standing the resident with resident's range of motion The resident could stand out issues with no redness or	{F 6	884}		

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{F 684}	and a walker nearby, initiated a personal a bed while resident or increased confusion (UTI). The ARNP was On 9/10/20 at 2:30 A explained the resider resident's skin color tarea was pink, with no The resident denied temperature was 97.50 On 9/10/20 at 5:51 A indicated that mornin around 5:40 AM; the with no cough noted, of a temperature of 9 respirations of 24, a land an oxygen satura. The Long-Term Care Visit dated 9/10/20 sl was a follow-up of the of the present illness was started on cephacellulitis of the penis streak going up the sof the visit on 9/3/20, clear with a normal V the last visit, the staff The staff reported the injuries but had becostaff noticed a decrearesident refused to exweek. The resident h during the overnight	lent had gripper socks on The new intervention larm on the resident while in antibiotics (ATB) related to with urinary tract infection is updated.  M, the Nursing Note int continued the ATB. The to the genital and perineal to blood in the catheter bag. If eeling unwell. The resident's if eeling unwell. The resident's if eeling unwell in the resident had audible wheeze if in the resident had vital signs if i	{F 6	884}		

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{F 684}	if the resident's signs cellulitis to the penis if further concerns. The following concerns.  1. Weakness 2. Encounter for Pallia Milky urine 4. Decreased oral inta Cellulitis of shaft of G. Fall, initial encount The plan stated to co cellulitis of the penis in symptoms. Due to decreased oral intake few days ago, plan to obtain a urine culture the ARNP planned to to weakness, milky us sooner PRN. The sta with any worsening sconcerns. The Physic without erythema but leaking around the caresident had copious discharge leaking around the caresident had copious discharge leaking around the care on 9/10/20. The catheter with 16 Fren obtained a urine sam culture. The nurse go	e novel coronavirus 2019 D. The staff could not report and symptoms of the improved. The staff had no e assessment showed the ative Care  ake If the penis er notinue on cephalexin for the with significant improvement the increased weakness, e, and a fall that occurred a draw lab and have staff. The follow-up plan showed follow-up in one week due rine, decreased appetite, or ff was encouraged to call igns, symptoms, or cal Exam showed the penis with milky colored urine atheter.  AM, the Nursing Note was seen during rounds by luation by the ARNP, the amounts of white/yellowish bund the catheter. A new or a urine culture, a complete rential (CBCD), and a bolic panel (CMP) to be enurse changed the current	{F 6	884}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R-C		
		165533	B. WING		09/17/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548	03/1//2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCED TO THE APPRENC	JLD BE COMPLETION	
{F 684}	the lab to come and  The New Orders for orders for a urinalysi and a CMP to be don  The CBCD results on the WBC count of 9.4.0 - 10.5. The result were reviewed. Staff while awaiting the re WBC count was with than it was eight day  On 9/10/20 at 3:35 Findicated a return favor results for the CBCD new orders at the tim  On 9/10/20 at 4:01 Fexplained a return favoresults from ARNP stated the resistaff was to encourage they were waiting for The ARNP's nurse si was aware of the resident within normal limits, ago. The ARNP's nu informed they were waiting for On 9/12/20 at 12:23 indicated the resident puss-like substance collection bag. The resident puss-like substance collection bag. The resident puss was waiting for the resident puss-like substance collection bag.	g. The facility was waiting for obtain a blood sample.  In dated 9/10/20 showed new is (UA) with a culture, CBCD, ne on 9/10/20.  In dependence on 9/10/20 showed the with a reference range of a notes showed the results was to encourage fluids sults of the urine culture. The in normal limits but higher is ago.  If the Nursing Note is received from the lab with and the CMP showing no obtained.	{F 684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		165533	B. WING _			R-C <b>09/17/2020</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1111 11TH AVE NORTH HUMBOLDT, IA 50548		3/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 684}	the resident continue of 98.2 F. The urine of 98.2 F. The urine of urine bag.  On 9/13/20 at 1:57 P the UA Culture return 1. greater than (>) 10 (CFU) / ML of Proteur of Enterococcus Face Pseudomonas Aerug  On 9/13/20 at 11:48 F explained the resident The resident's temper resident continued to around the catheter.  On 9/13/20 at 9:51 P Administrative Note in monitored the urethrableeding, swelling, pasymptoms every Sundocumented the resident dender than usual green drainage seen results showed that coresident finished earlione of the tested mediacteria. The ARNP during rounds on 9/14  On 9/14/20 at 2:47 P explained the facility the ARNP with results 9/10/2020. The ARNF	M, the Nursing Note showed d ATBs with a temperature output was cloudy in the  M, the Nursing Note showed ed with the following noted: 0,000 colony-forming unit is Mirabilis 2. 30000 CFU/ML of inosa.  PM, the Nursing Note in the trinished the cephalexin. In the trature was 98 F, and the have pain and discharge  M, the Orders - Indicated the nurse all erosion weekly for ain, infection signs, and day at bedtime. The nurse dent's penis was more pink in, with a scant amount of around the catheter. The lab ephalexin, the antibiotic the iter that day, was not listed as dications against the would see the resident 4/20.	{F 68	34}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII	FIPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED	
		165533	B. WING _			R-C <b>09/17/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1111 11TH AVE NORTH HUMBOLDT, IA 50548	DDE	03/1//2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 684}	that afternoon by the were as follows:1. Cipextended-release (EF Probiotic everyday 3. to the reddened area PRN.  The New Orders form ARNP gave orders for every twenty-four hot daily, and apply the preddened areas of th.  The Laboratory Results the UA Culture return 1. greater than (>) 10 (CFU) / ML of Proteu of Enterococcus Faee Pseudomonas Aerug the urine culture shown reviewed, and the rescephalexin.  The Respiratory Infer assessment informat symptoms. The resid lacked completed assessment infection.  The Infection Control showed the resident The first UTI showed diagnosis was a red spenis. The second in	M, the Nursing Note It was seen during rounds ARNP. New orders received profloxacin 500 mg R) every day for five days 2. Apply a protective ointment is of groin twice daily and In dated 9/14/20, showed the pur Ciprofloxacin 500 mg ER purs for five days, a probiotic protective ointment to the regroin twice daily and PRN. Its noted on 9/14/20 showed red with the following noted: r0,000 colony-forming unit red simple sident continued on Streener lacked red ion related to urinary rent's assessments tab resessments on the following red for the month of 9/20 red for the month of 9/20 red for the log with a UTI.	{F 6	84}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′		(X3) DATE SURVEY COMPLETED		
	165533	B. WING		R-C <b>09/17/2020</b>		
	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548	1 03/11/2020		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
catheter was changed. The Documentation showed the urinary on the 6:00 AM - 2:00 the 2:00 PM - 10:00. The resident's record related to daily assess resident's cellulitis on Resident #5 has a C 9/16/20, that indicate elimination using an diagnosis of BPH and resident was admitted erosion from the cath was ordered. The Cafollowing intervention 1. History of a UTI, Enot contraindicated. PRN. Probiotic as or 2. Monitor urethral edification of a UTI selection of the nurse of bleeding, swelling 3. Monitor, document symptoms of a UTI selection of the nurse of the n	Survey for the month of 9/20 putput on 9/10/20 of 1700 ml 0 PM shift and 250 ml during PM.  I lacked documentation assents related to the rurinary symptoms.  The rurinary symptoms dated an alteration in urinary indwelling catheter-related durinary retention. The adwith a history of urethral meter. On 9/16/20, an ATB are Plan problem included the ms.  Encourage fluids as long as May offer cranberry juice dered dated 9/15/20. The rosion weekly for symptoms and pain dated 6/2/19. The related urine, low back pain, that status or alertness. For provider if symptoms were a with a revision date of resident had a self-care aired cognitive status. The osis of cardiomegaly, atrial apnea. The Care Plan	{F 684	1)			
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag catheter was change at the er was change on the 6:00 AM - 2:00 the 2:00 PM - 10:00  The resident's record related to daily assess resident's cellulitis on Resident #5 has a C 9/16/20, that indicate elimination using an diagnosis of BPH an resident was admitted erosion from the cath was ordered. The Cafollowing intervention 1. History of a UTI, Enot contraindicated. PRN. Probiotic as on 2. Monitor urethral erof bleeding, swelling 3. Monitor, documen symptoms of a UTI scloudy, dark, concent and changes in men Report to the nurse on the contraindicated to impare symptoms of a UTI scloudy, dark, concent and changes in men Report to the nurse on the contraindicated to impare included the deficit related to impare sident had a diagn fibrillation, and sleep problem included the 1. Report to the nurse of the nurse of the contraindicated to impare included the 1. Report to the nurse of the nurse of the contraindicated to impare included the 1. Report to the nurse of the	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17 catheter was changed on 9/3/20 and 9/10/20.  The Documentation Survey for the month of 9/20 showed the urinary output on 9/10/20 of 1700 ml on the 6:00 AM - 2:00 PM shift and 250 ml during the 2:00 PM - 10:00 PM.  The resident's record lacked documentation related to daily assessments related to the resident's cellulitis or urinary symptoms.  Resident #5 has a Care Plan problem dated 9/16/20, that indicated an alteration in urinary elimination using an indwelling catheter-related diagnosis of BPH and urinary retention. The resident was admitted with a history of urethral erosion from the catheter. On 9/16/20, an ATB was ordered. The Care Plan problem included the following interventions.  1. History of a UTI, Encourage fluids as long as not contraindicated. May offer cranberry juice PRN. Probiotic as ordered dated 9/15/20.  2. Monitor urethral erosion weekly for symptoms of bleeding, swelling, and pain dated 6/2/19.  3. Monitor, document, and report PRN signs or symptoms of a UTI such as foul-smelling urine, cloudy, dark, concentrated urine, low back pain, and changes in mental status or alertness. Report to the nurse or provider if symptoms were	ROVIDER OR SUPPLIER  BOLDT NORTH, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17 catheter was changed on 9/3/20 and 9/10/20.  The Documentation Survey for the month of 9/20 showed the urinary output on 9/10/20 of 1700 ml on the 6:00 AM - 2:00 PM shift and 250 ml during the 2:00 PM - 10:00 PM.  The resident's record lacked documentation related to daily assessments related to the resident's cellulitis or urinary symptoms.  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The resident had a diagnosis of cardiomegaly, atrial fibrillation, and sleep apnea. The Care Plan problem included the following interventions.  1. Report to the nurse any unusually foul-smelling	ROVIDER OR SUPPLIER  165533  ROVIDER OR SUPPLIER  180LDT NORTH, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLU (EACH DEFICIENCY)  Continued From page 17  catheter was changed on 9/3/20 and 9/10/20.  The Documentation Survey for the month of 9/20 showed the urinary output on 9/10/20 of 1700 ml on the 6:00 AM - 2:00 PM shift and 250 ml during the 2:00 PM - 10:00 PM.  The resident's record lacked documentation related to daily assessments related to the resident's cellulitis or urinary symptoms.  Resident #5 has a Care Plan problem dated 9/16/20, that indicated an alteration in urinary elimination using an indwelling catheter-related diagnosis of BPH and urinary retention. The resident was admitted with a history of urethral erosion from the catheter. 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		165533	B. WING				-C 17/2020
	ROVIDER OR SUPPLIER  BOLDT NORTH, LLC			111	REET ADDRESS, CITY, STATE, ZIP CODE  11 11TH AVE NORTH  JMBOLDT, IA 50548	<u>  09/</u>	17/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	provider dated 2/22/12. The resident was a the need to use the tresident to the toilet p. The staff was to repoinvoluntary episodes.  During interview on 9. Registered Nurse (R. were completed in the nurse report sheet in charted on. Staff A sh. Nursing Communicated name on it, showing assessed for the use.  On 9/17/20 at 11:20 a unless the staff was a not everything got do tended to follow-up mare identification from the staff was a not everything to the they weren't sure if the detrimental to the resident and the cultures show UTI. The ARNP said about the resident's company on the staff was going on. Until the 9/10/20, they were up the resident's urine. Tresident up to assess	and/or urgency to nurse or 9.  able to recognize and voice oilet. Staff was to assist the per their request and PRN.  In the catheter leaking or dated 2/22/19.  In 17/20 at 10:01 AM, Staff A, N), stated that assessments ecomputer. They use the dicating who needed to be nowed the surveyor the ion sheet with the resident's the resident was to be of antibiotics.  AM, the ARNP explained that especifically asked for things, one. The ARNP said they nore frequently with the always getting all the facility. The ARNP stated ne infection would be eident because they were for the cellulitis in the penis wed it should've covered the when they asked the staff condition, no one knew what the ARNP saw the resident on naware of any concerns with then when they stood the stafe penis, urine was leaking The ARNP stated the	{F 6	84}			
		proved since 7/20. The should be assessing the resident had those					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		165533	B. WING			l	-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1111 11TH AVE NORTH HUMBOLDT, IA 50548	IP CODE	1 03/	17/2020
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{F 684}	Continued From page		{F 6	84}			
F 880 SS=E	document the resident appearance and would the resident's urine. To stated they thought the not cellulitis, as they journed the resident had cellulitis, stated the facility need communication with the Communication with the Quality Assurance Stewardship Program best practice guideling the evaluation and consigns and symptoms as suspected of having a use of diagnostic test. "antibiotic time-out" for the facility. The stand improving the evaluated clinical signs and symfirst suspected of have Antimicrobial Steward assess information, a that proper data collewas completed. Infection Prevention & CFR(s): 483.80(a)(1)(1)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	y would expect the staff to t's affected area's d expect the staff to assess the Infection Preventionist e antibiotic was for a UTI, ust learned that day the The Infection Preventionist ded to work on their ne Doctor's office, too.  e: Antimicrobial d dated 3/25/19 stated the es would include improving mmunication of clinical when a resident was first an infection, optimizing the ing, then implementing an or all antibiotics prescribed in ards would include ion and communication of uptoms when a resident was ing an infection. The liship Program Team would udit findings, and ensure ction and documentation  a Control (2)(4)(e)(f)  Introl blish and maintain an and control program safe, sanitary and ent and to help prevent the asmission of communicable	F	880			

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F 880	Continued From pag	e 20	F 88	50	
	program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syst reporting, investigating and communicable distaff, volunteers, visity providing services unducted according accepted national states §483.80(a)(2) Written procedures for the pubut are not limited to (i) A system of surver possible communication infections before the persons in the facility (ii) When and to who communicable diseat reported; (iii) Standard and trates.	em for preventing, identifying, ng, and controlling infections iseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, it illiance designed to identify ble diseases or y can spread to other			
	(iv)When and how is resident; including but (A) The type and dur depending upon the involved, and (B) A requirement the least restrictive possicircumstances.  (v) The circumstance	olation should be used for a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		165533	B. WING			R-C <b>09/17/2020</b>
	ROVIDER OR SUPPLIER  BOLDT NORTH, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548		03/11/2020
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F 880	contact with resident contact will transmit (vi)The hand hygient by staff involved in contact will transmit (vi)The hand hygient by staff involved in contact will transmit staff involved in contact with the corrective actions the corrective actions the staff involved in control profession.  §483.80(e) Linens. Personnel must han transport linens so a infection.  §483.80(f) Annual resident from the facility will cond IPCP and update the This REQUIREMEN by:  Based on observation reviews, the facility for infection control profession for Novel Coronavirus facility reported a certain facility reported a certain facility reported a certain facility infection control profession include:  1. The Minimum Data Resident #5 with an (ARD) of 7/1/20 shown Mental Status (BIMS severe cognitive imprequired extensive a toileting and personal an indwelling catheter resident had diagnosprostatic hyperplasia.	skin lesions from direct ts or their food, if direct the disease; and e procedures to be followed irect resident contact.  The for recording incidents facility's IPCP and the ken by the facility.  The facility of the facility of the facility of the facility.	F 88	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548	1 03/1//2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION
F 880	completion on the fo 8/22/20, 8/23/20, 8/23/20, 8/23/20, 8/31/20, 9/3/20, 9/7/  The resident's record screenings to rule on 2. The MDS completed ARD of 7/23/20 show indicating moderate resident had diagnosun specified, paroxys atherosclerotic heart coronary artery without the Respiratory Infection on the for 8/24/20, 8/25/20, 8/25/20, 8/25/20, and 9/15/20. The resident's record screenings to rule of 3. The MDS completion on the formal cating intact cognidicating intact cognidicating intact cognidicating, and other the Respiratory Infections, and other the Respiratory Infection on the formal cating in the formal completion on the formal cating in the formal completion on the formal cating in th	action Screener lacked llowing dates: 8/20/20, 8/4/20, 8/25/20, 8/28/20, 20, 9/14/20, and 9/15/20.  Id lacked additional at COVID-19.  Ited for Resident #1 with an wed a BIMS score of 9, cognitive impairment. The ses of sleep apnea, smal atrial fibrillation, and a disease of the native but angina pectoris.  Indication Screener lacked llowing dates: 8/20/20, 8/31/20, 9/3/20, 9/7/20, 0).  Id lacked additional at COVID-19.  Ited for Resident #3 with an wed a BIMS score of 15, inition. The resident had all infarction without residual story of urinary (tract) specified hypothyroidism.  Incition Screener lacked llowing dates: 8/17/20, 8/1/20, 9/3/20, 9/7/20, 9/10/20, 0).	F 880		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548		09/1//2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 880	screenings to rule of 4. The MDS completance of 8/19/20 shot indicating intact cogdiagnoses of pleural classified, chronic at and pneumonia, unsured on 9/17/20 at 10:51 Registered Nurse (Face mask covering exposed while completance).  The Respiratory Infectompletion on the fallow of 8/12/20, 9/2/20, 9/2/20, 9/2/20, 8/31/20, 9/2/20, 8/31/20, 9/2/20, 8/31/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 10 completion on the fallow of 8/19/20, 8/24/20, 8/3/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 10 completion on the fallow of 8/19/20, 8/24/20, 8/24/20, 8/24/20, 8/24/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 10 completion on the fallow of 8/19/20, 8/24/20, 8/24/20, 8/24/20, 8/24/20, 8/24/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/20, 9/1/20, 9/2/	eted for Resident #6 with an wed a BIMS score of 15, inition. The resident had I effusion, not elsewhere trial fibrillation, unspecified, specified organism.  AM, observed Staff A, RN), wearing goggles with a their mouth with nose oleting the resident's dressing ection Screener lacked ollowing dates: 8/27/20, 2/20, 9/14/20, and 9/15/20.  Indicated additional ut COVID-19.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.  Interested for Resident #7 with an wed a BIMS score of 2, agnitive impairment. The lases, vitamin d deficiency, hizophrenia, unspecified.	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		' '	DATE SURVEY COMPLETED
		165533	B. WING _			R-C <b>09/17/2020</b>
NAME OF PROVIDER OR SUPPLIER  QHC HUMBOLDT NORTH, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE  1111 11TH AVE NORTH  HUMBOLDT, IA 50548		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 880	diagnoses of morbid excess calories, schi suicidal ideations, an without complications.  The Respiratory Infectompletion on the fol 8/23/20, 8/24/20, 8/2 9/3/20, 9/7/20, 9/14/2  The resident's record screenings to rule outous of the resident's record screenings to rule outous outous of the resident of t	(severe) obesity due to zophrenia, unspecified, d type 2 diabetes mellitus s	F8	80		